Rehabilitation Referral

Referral to:

- □ **Physiotherapy**
- □ **Occupational Therapy**
- □ **Speech/Language Pathology**

HC#	WSIB#
Name:	
Address:	
Contact Numbers Home: _____ Cell: _____	
Date of Referral:	
Date of Onset:	D.O.B:
Allergies:	Physician:

Diagnosis:

□ Acute (<4 weeks) □ Sub Acute (4-12 weeks) □ Chronic (>12 weeks)

Medical History:

Medications:

Are there metal plates, screws, sutures etc?

Level of Weight Bearing □ Full □ Partial □ Non-Weight Bearing (check one please)

Medical Conditions which may affect therapy? (Heart condition, Epilepsy, Diabetes, etc.)

Aims of Treatment:

Physician's Signature:

Fax Completed Forms to:

Riverside Health Care
Attn: Rehab Department
Fax: (807)-274-4841
Phone: (807)-274-4815